



European Testing Kits Order Form

Date: _____

Event Name: _____

Event Address: _____

City: _____ Zip: _____

Country: _____ Start date of event: _____
(Send in a copy of the show schedule with this form.)

Show Number(s): _____

Number of expected horses at event: _____

Number of NRHA medication test kits needed at Event: _____ (= number of horses / 20)

Show secretary: _____ NRHA ID: _____

Phone: _____ Email address: _____

Show manager: _____ NRHA ID: _____

Phone: _____ Email address: _____

Invoice information for testing:

Legal entity or individual responsible for payment: _____

Address: _____

City: _____ Zip: _____

Country: _____

Phone: _____ Email address: _____

Signature: _____

Mail this form to euromedications@nrha.com no later than two (2) weeks before the start of the event.